AdventHealth Centra Care | Corporate Care

AUTHORIZATION TO TREAT FORM

Send completed Authorization Form to:
CorpCareScheduling@adventhealth.com

Clinic Locations

☐ **Centra Care Overland Park**
9099 W 135th Street
Overland Park, KS 66221
Phone: 913-549-4242
Fax: 913-602-8911
M-F, 8am - 8pm. Weekends: 8am - 5pm

☐ **Centra Care Olathe**
14744 W 119th Street,
Olathe, KS 66062
Phone: 913-839-1759
Fax: 913-839-9588
M-F, 8am - 8pm. Weekends: 8am - 5pm

☐ **Centra Care Shawnee**
11245 Shawnee Mission Parkway
Shawnee, KS 66203
Phone: 913-268-4455
Fax: 913-268-4493
M-F, 8am - 8pm. Weekends: 8am - 5pm

Patient Name:_____ **Date**:_____ **Time Authorized**: _____
Please Print

Employer Name: _____

Employer Address:_____

Date/Time Patient will arrive at clinic (if known): _____ **Job Title:**_____

Authorized By: _____ _____ **Phone**: _____
Print Name *Signature*

Email of Authorizing Individual: _____

SERVICES: Reservations Welcome: www.centracarekc.com

DRUG TEST: If DOT/Federal, Must Identify DOT Agency: ☐ **FMCSA** ☐ **FAA** ☐ **FTA** ☐ **USCG** ☐ **PHMSA** ☐ **FRA**

Drug Test Reason: ☐ **NON-DOT (Non-Federal)** ☐ **DOT (Federal)**

☐ Pre-Employment
☐ Post-Injury (NON-DOT)
☐ Follow-up
☐ Random
☐ Post-Accident/Vehicle
☐ Other (Specify) _____
☐ Reasonable Suspicion
☐ Return-to-Duty (DOT ONLY)
☐ Return-to-Work

Drug Test Type:

Drug Screen: ☐ Urine Drug Test 5-Panel ☐ Urine Drug Test 10-Panel Expanded
☐ *INSTANT* Urine 5-Panel ☐ *INSTANT* Urine 10-Panel
☐ Saliva/Oral Fluid 10-Panel ☐ CISAP ☐ Hair Test
☐ COLLECT ONLY (Outside Lab) ☐ MCA (Pipefitters/Plumbers) ☐ **Other:** _____
Alcohol: ☐ Breath Alcohol ☐ NON-DOT (Non-Federal) ☐ DOT (Federal)

INJURY WORK-RELATED: **Drug Screen Required:** ☐**YES** ☐**NO** **Specify drug screen above.**

Date of Injury:_____Time of Injury:_____Body Part Injured:_____Claim #:_____

Describe Injury: _____

Workers' Comp Insurance Carrier:_____ Phone: _____

Claim#: _____ Policy No. _____ Policy Expiration: _____

Carrier Remit To Address For Invoice: _____

EXAM: ☐ Post-Offer ☐ Annual ☐ DOT (Post-Offer or Re-Cert) **JOB TITLE**: _____

Other: Vaccinations: ☐ Hepatitis B 3-dose ☐ TB Skin Test ☐ TB Blood Test (IGRA/TSPOT)
☐ Audiogram

☐ **OTHER (SPECIFY)**: _____
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